

AccuReview

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[Date notice sent to all parties]: June 14, 2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left L3-4 Transforaminal Epidural Steroid Injection, L3 Nerve Block Injection

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

This physician is Board Certified in Anesthesiology with over 14 year of experience.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld

(Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

This claimant is a male who sustained a back injury on XX/XX/XX when a swinging sledge hammer slipped and "twisted him around" after hitting the metal and slipping. Current diagnosis includes lumbago and herniated nucleus pulposus at L3-4, L4-5 and L5-S1.

XX/XX/XX: Re-Evaluation & Plan of Care. CC: Claimant has been seen at PT 9 visits for his low back and L leg pain following an injury at work on XX/XX/XX. Pain rated 8-9/10 at worst but he does report that his leg pain and frequency of leg pain has improved. He reports good HEP compliance with the "McKenzie" approach to LBP. TTP: L lumbar paraspinal mm from L2 to sacrum, spinous process of L4-5, L PSIS, sacrum and L gluteals. Overall assessment: Claimant has been seen at PT visits with improved radicular sx's (no longer constant as well as less painful when present and not going down the leg so far). He continued to have constant and significant LBP which he is supposed to see pain management however there has been a hang up due to the providers in the area not being in-network. Plan: Request 10 additional PT visits to complete.

XX/XX/XX: MRI Lumbar Spine without Contrast. Impression: 1. Left foraminal/extraforaminal disc herniations at L4/5 and to a lesser extent at L3/4 that contact their respective exiting nerve roots. 2. Central disc herniation at L5/S1. There is no significant central canal or neural foraminal stenosis at this level.

XX/XX/XX: Progress Note. CC: LBP. PE: Lumbosacral Spine: palpation: tender to T10/sacrum, decreased sensation in dermatomes on L compared on the R L5-S1. Tests/Signs: SLR positive on left w/ left buttock pain and R causes left buttock pain. Radiology Results: Lumbosacral Spine: views obtained today show normal flexion and extension views, straightening Iodonic curve creating a flat back picture due to spasm. Assessment: Lumbago 724.2, Herniated Lumbar Disc (HNP) @ L4-5, L3-4, L5-S1 722.10. Plan: consultation for pain management in XX for ESI treatment, PT McKenzie extension protocol

XX/XX/XX: Nerve Conduction Studies and Electromyography. Interpretation and Conclusion: This is an abnormal study. There were recurrent runs of positive sharp waves in the left low lumbar paraspinal muscles suggesting that nerve root pathology is present, but it does not identify the exact nerve root involved. It was an isolated abnormality. Nerve conduction studies of the left lower extremity were unremarkable. Conduction studies were performed along the left peroneal, tibial, sural, and superficial peroneal nerves. F-wave studies were performed along the left peroneal and tibial nerves. Conduction velocities, latencies, and amplitudes are normal.

XX/XX/XX: Progress Note. CC: LBP, follow up visit. PE: Lumbosacral Spine: palpation: tender to T10/sacrum, decreased sensation in dermatomes on L compared on the R L5-S1. Tests/Signs: SLR positive on left w/ left buttock pain and R causes left buttock pain. Assessment: Lumbago 724.2, Herniated Lumbar Disc (HNP) @ L4-5, L3-4, L5-S1 722.10. Plan: Explained EMG results indicate pressure on the nerve at L4-5. Suggest a discectomy to reduce the pressure on the nerve at L4-5. Also discussed weight management to reduce stress on his back, as well as smoking cessation to avoid delayed healing. Follow up for pain management. The following procedure is recommended: L4-5 far lateral discectomy with radiculopathy. Return 10-14 days after surgery.

XX/XX/XX: Progress Note. CC: LBP, follow up visit. Medication List: Robaxin 500mg, Robitussin cold-flu day, and tramadol 50mg. PE: Lumbosacral Spine: palpation: tender to T10/sacrum, decreased sensation in dermatomes on L compared on the R L5-S1, SLR positive on left crossover test R to L at full extension on left, SLR markley positive 20* lag on the left, decreased sensation L5/S1 dermatomes on the left, L4/S1 on the left, mild EHL weakness on the left compared to the right. Assessment: Lumbago 724.2, Herniated Lumbar Disc (HNP) @ L4-5, L3-4, L5-S1 722.10. Plan: discussed the paperwork stating the denial of the surgery. Claimant stated that XX refused to see him due to the fact that he treats headaches not back pain. The claimant related his lower back pain radiates down the left buttock, lateral leg around the top of foot to the medial arch, this is an L5 distribution. He has trouble maintaining a heel walk on the left. Gave prescription for Norco 5/325.

XX/XX/XX: Operative Report. Preoperative Diagnosis: 1. L4-5 far-lateral left herniated nucleus pulposus. 2. Left lower extremity radiculopathy. Postoperative Diagnosis: 1. L4-5 far-lateral left herniated nucleus pulposus. 2. Left lower extremity radiculopathy. Procedures Performed: 1. Far-lateral L4-5 left-sided discectomy. 2. Intraoperative C-arm image intensification for verification of level. 3. Intraoperative microdissection using Zeiss operating microscope.

XX/XX/XX: MRI Lumbar Spine. Impression: 1. Evidence of prior surgical intervention, probable partial laminectomy L4-5 with suspected residual/recurrent far left posterior lateral disc bulge/protrusion with fibrosis/granulation tissue within, contacting and deflecting the intraforaminal and already exited left L4 nerve root. 2. L3-4 far left posterior lateral disc bulge/protrusion contacts and deflects the intraforaminal and already exited left L3 nerve root. 3. Otherwise no likely potential for lumbar nerve impingement despite multilevel canal and neural exit foramen compromise described.

XX/XX/XX: Progress Note. CC: LBP, post-operative visit. Medication List: ibuprofen 600mg, Medrol dose pak, robaxin 500mg, robitussin cold-flu day, tramadol 50mg, and Tylenol #4. PE: Lumbosacral Spine: Palpation: tender from T10/sacrum, decreased sensation in dermatomes on L compared on the R L5-S1, mild EHL weakness on the left compared to the right, decreased sensation of the lateral left leg and medial right anterior calf. Muscle Strength: unable to maintain a heel walk due to weakness but has a good toe walk B. SLR positive on the left produces lateral hip, knee and anterior thigh pain, SLR positive on the right causes left sided hip, thigh pain, positive cross over test. Assessment: Herniated Lumbar Disc HNP @ L4-5, L3-4, L5-S1 722.10, Lumbago 724.2. Plan: consultation referral for ESI injections at L3-4. Medications: Tylenol #4.

XX/XX/XX: Progress Note. CC: LBP. Medication List: ibuprofen 600mg, Medrol dose pak, robaxin 500mg, robitussin cold-flu day, tramadol 50mg, and Tylenol #4. PE: Lumbosacral Spine: Palpation: decreased sensation in the L4 dermatome on the left and along the medial and plantar calcaneous. Muscle strength: trouble maintaining a heel walk because of weakness, he can only walk on the sides of his feet, he cannot get on his heels, he cannot get on his toes. Tests: SLR positive on the left produces big toe, thigh, and gluteal pain, SLR positive on the right causes a crossover a positive left gluteal pain. Gait: walks with a limp and uses a cane. Assessment: Herniated Lumbar Disc

HNP @ L4-5, L3-4, L5-S1 722.10, Lumbago 724.2. Plan: Claimant has an L3-4 left lateral disc herniation and he has a possible reoccurrence at L4-5. He continues to have pain and weakness and has to now ambulate with a cane because of his weakness and numbness in his leg. I still feel that it is medically necessary to have the injections and/or potential surgical intervention. HE has a DDE that is set to schedule at some point. He is to remain off duty and I will see him back in 6 weeks.

XX/XX/XX: Report of Medical Evaluation. Current Medications and Treatment: Medications: OxyContin 10/325 mg TID, Lyrica HS, gabapentin gave him a rash, so then he switched to Lyrica, meloxicam and cyclobenzaprine BID. Treatment: One lumbar ESI and one small discectomy at L4-5, PT before surgery for three weeks only prior to the MRI, none after that. Extensive surgery at the time of the first surgery and PT all were denied by the insurance company despite multiple requests by his attending physician for more treatment. Summary and Comments: DX: lumbar strain/sprain, L4-5 herniated nucleus pulposus, status post back surgery for L4-5 partial discectomy. Additional diagnoses are: herniated nucleus pulposus L3-4 and L5-S1. Extent of Injury: lumbar strain/sprain, herniated nucleus pulposus L4-5, s/p lumbar back surgery with partial discectomy at L4-5. Diagnoses in question are: L3-4 bulge/protrusion, aggravation of spondylosis at L3-4, aggravation of spondylosis at L5-S1, L5-S1 bulge/HNP. To reasonable medical probability, is the mechanism of injury a substantial factor in bringing about the L3-4 bulge/protrusion, aggravation of spondylosis at L3-4, aggravation of spondylosis at L5-S1 bulge/HNP? Answer: These are all of the injuries and diagnosis in question claimed to be caused by or naturally resulting from the accident or injury. The composite of the questions are addressed together, since in essence they all refer to the same area of the body. After completion of a comprehensive evaluation, the claimant was found to have not reached MMI. He is not at MMI as XX is encouraging both additional injections for the claimant plus potential surgery. XX is his attending physician and has not released him.

XX/XX/XX: Progress Note. CC: LBP. Medication List: ibuprofen 600mg, Medrol dose pak, robaxin 500mg, robitussin cold-flu day, tramadol, and Tylenol #4. PE: Lumbosacral Spine: Palpation: decreased sensation in the L4 dermatome on the left and along the medial and plantar calcaneous. Muscle Strength: trouble maintaining a heel walk because of weakness, he can only walk on the sides of his feet, he cannot get on his heels, he cannot get on his toes. Tests: SLR positive on left produces big toe, thigh, and gluteal pain, SLR test positive on the right causes a crossover a positive left gluteal pain. Assessment: lumbago 724.2/M54.5, Herniated nucleus pulposus, L3-4 and L4-5 722.10/M51.26, Herniated nucleus pulposus, L5-S1 722.10/M51.27. Plan: claimant is still experiencing low back pain with radiculopathy and weakness and numbness down the left leg. Still feel strongly that he requires more treatment to include either injections or surgery. His designated doctor's exam was also in agreement for further treatment.

XX/XX/XX: Initial Evaluation & Plan of Care. CC: claimant presented with complaints of L sided low back and leg pain that began after injury at work on XX. Claimant has had previous discectomy at lower lumbar spine in XX/XX/XX with resolution of posterior leg sx's but now sx's are anterior thigh and shin. Pain is rated at 8/10 at worst, 5/10 at best; pain is aggravated by lifting, walking, driving; pain is eased by lying down and pain medication. Claimant reports previous hx of L leg weakness and requiring a cane to walk but that has since resolved and notes no LLE weakness. Sleep is disturbed 3-4x/week due to pain. TTP: L piriformis, L lumbar paraspinals, decreased sensation to light touch on L3-S1 on L compared to RLE. PROM: L>R hip PROM limitations due to pain. +SLR on L at 30*. Initial Assessment: Claimant presented with chronic low back pain along the L LE radiculopathy from work injury on XX/XX/XX. Pain pattern implicates mid lumbar spine and directional preference towards extension is promising that we can centralize and manage sx's with McKenzie based exercises. Plan: PT will consist of manual therapy, therapeutic exercise, HEP, pain education 2x/week x 8 weeks.

XX/XX/XX: Report of Medical Evaluation. Summary and Comments: DX: 1. Lumbar strain, 2. L4-5 broad-based disc herniation, 3. Disc bulges/herniations at L3-4 and L5-S1, 4. Spondylosis at L3-4 and L5-S1. MMI: The claimant was found to have not reached MMI. The claimant is not at MMI because the insurance company has denied treatment both prior to and after the hearing officer, XX, has made the order stating, "The carrier is ordered to pay benefits in accordance with this decision, the TWCA and the Commissioner's rules. Accrued but unpaid income benefits, if any shall be paid in a lump sum together with interest as prepared by law". Also, it is not stated by the decision that the compensable injury of XX/XX/XX, does extend to and include disc bulges/herniations at L3-4 and L5-S1, spondylosis at L3-4 and L5-S1 means that the insurance company is required to provide reasonable treatment to the examinee as per

the Physician Guidelines. Thus, the claimant is not at MMI as he has not received treatment that would provide him with a benefit so that he may return to work. Since he is not at MMI, an impairment rating cannot be given.

XX/XX/XX: UR. Reason for denial: Based on clinical information submitted for this review and using evidence-based, peer-reviewed guidelines referenced above, this request is Non-Certified. The recent clinical examination findings were not fully suggestive of a radiculopathy at the requested level. In addition, there was no indication that the claimant has received a recent course of adequate conservative treatment including skilled therapy.

XX/XX/XX: Progress Note. CC: LBP. Follow up visit. PE: Lumbosacral Spine: Palpation: decreased sensation in the L4 dermatome on the left and along the medial and plantar calcaneous. Muscle Strength: trouble maintaining a heel walk because of weakness, he can only walk on the sides of his feet, he cannot get on his heels, he cannot get on his toes. Tests: SLR positive on left produces big toe, thigh, and gluteal pain, SLR test positive on the right causes a crossover a positive left gluteal pain. Assessment: lumbago 724.2/M54.5, Herniated nucleus pulposus, L3-4 and L4-5 722.10/M51.26, Herniated nucleus pulposus, L5-S1 722.10/M51.27. Plan: Claimant has continued symptoms since his last visit. As this time, it is felt as though he could have some residual pressure in his back. Therefore, again recommend ESI into his low back to help with his pain so he can perform his McKenzie exercises. Based on the circumferential difference between the left and right leg, I feel as though it is due to the radiculopathy on the left he has. His work restrictions are to remain the same and return in 6-8 weeks.

XX/XX/XX: UR. Reason for denial: Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. The claimant presented with radiating low back pain with MRI findings showing left L3 and L4 nerve root compromise. He had documented findings suggestive of radiculopathy along the L4 distribution. However, there is no indication for an L3 nerve block in addition to a transforaminal ESI at L3-4. Based on the clinical information provided, the medical necessity of the requested is not fully substantiated. Although the left L3-4 ESI is warranted, the request for the left L3 nerve block has not been determined to be medically necessary. Therefore, the previous determination is upheld.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. Claimant’s MRI showed left L3 and L4 nerve root compromise. Claimant also presented with radiating low back pain. He had documented findings suggestive of radiculopathy along the L4 distribution. However, there is no indication for an L3 nerve block in addition to a transforaminal ESI at L3-4. Based on the clinical information provided, per ODG, the medical necessity of the requested is not fully substantiated. Therefore, after reviewing the medical records and documentation provided, the request for Left L3-4 Transforaminal Epidural Steroid Injection, L3 Nerve Block Injection is not medically necessary and non-certified.

Per ODG:

Epidural steroid injections (ESIs), therapeutic	<p>Criteria for the use of Epidural steroid injections:</p> <p><i>Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, reduction of medication use and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.</i></p> <p>(1) Radiculopathy (due to herniated nucleus pulposus, but not spinal stenosis) must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing.</p> <p>(2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs, muscle relaxants & neuropathic drugs).</p>
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- (3) Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance.
- (4) *Diagnostic Phase:* At the time of initial use of an ESI (formally referred to as the “diagnostic phase” as initial injections indicate whether success will be obtained with this treatment intervention), a maximum of one to two injections should be performed. A repeat block is not recommended if there is inadequate response to the first block (< 30% is a standard placebo response). A second block is also not indicated if the first block is accurately placed unless: (a) there is a question of the pain generator; (b) there was possibility of inaccurate placement; or (c) there is evidence of multilevel pathology. In these cases a different level or approach might be proposed. There should be an interval of at least one to two weeks between injections.
- (5) No more than two nerve root levels should be injected using transforaminal blocks.
- (6) No more than one interlaminar level should be injected at one session.
- (7) *Therapeutic phase:* If after the initial block/blocks are given (see “Diagnostic Phase” above) and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be supported. This is generally referred to as the “therapeutic phase.” Indications for repeat blocks include acute exacerbation of pain, or new onset of radicular symptoms. The general consensus recommendation is for no more than 4 blocks per region per year. ([CMS, 2004](#)) ([Boswell, 2007](#))
- (8) Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response.
- (9) Current research does not support a routine use of a “series-of-three” injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections for the initial phase and rarely more than 2 for therapeutic treatment.
- (10) It is currently not recommended to perform epidural blocks on the same day of treatment as facet blocks or sacroiliac blocks or lumbar sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment.
- (11) Cervical and lumbar epidural steroid injection should not be performed on the same day. (Doing both injections on the same day could result in an excessive dose of steroids, which can be dangerous, and not worth the risk for a treatment that has no long-term benefit.)

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- ☐ AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- ☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- ☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- ☐ INTERQUAL CRITERIA
- ☒ MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- ☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- ☐ MILLIMAN CARE GUIDELINES
- ☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- ☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- ☐ TEXAS TACADA GUIDELINES
- ☐ TMF SCREENING CRITERIA MANUAL
- ☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- ☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)